KANSAS SURGICAL HOSPITAL ASSOCIATION
Statement of
Jim Sergeant, CEO Salina Surgical Hospital, and
Past-President of KSHA
to the
Kansas Health Policy Authority
July 27, 2006
Hays, Kansas

Executive Director Nielsen and members of the Health Policy Authority, my name is Jim Sergeant, I am the CEO of Salina Surgical Hospital and past president of KSHA. I would like to thank you for this opportunity to discuss the issue of hospital licensure. As you know, during the 2006 Kansas legislative session, revision of the current Kansas hospital licensure laws was attempted via the introduction of H.B. 3013. A proviso included in the Omnibus Appropriations Bill directs you, the Kansas Health Policy Authority, to conduct a review and study of the issues related to specialty hospitals and Kansas hospital licensure laws, and bring forth recommendations by March 1, 2007. The members of KSHA and I are more than happy to assist you with any questions you might have about our industry.

Salina Surgical Hospital is a 16 bed surgical hospital that is a joint venture with Salina Regional Health Center, 32 surgeons and 3 local businessmen. SSH opened its doors in 1999. The Kansas Surgical Hospital Association, which is an association of 8 specialty hospitals in Kansas of which 25% of our members are a joint venture of hospitals and physicians, 50% joint venture of private investors and physicians, and the remaining 25% are 100% physician owned.

I have also worked in the healthcare industry since the early 80's in the capacity of physician practices manager, business development, hospital operations, legislative liaison work, managed care contracting and CEO. So I feel I have a broad range of experience in the subject matter in which I am speaking.

Currently most of our membership is licensed as Specialty Hospitals along with the Rehabilitation and Long Term Acute Care Hospitals. Our membership feels that the specialty hospital category is appropriate. The language that was proposed on H.B.3013 singled out only surgical hospitals and would refer to us as "limited care facilities", this description could not be further from the truth. Each Specialty Hospital provides comprehensive services such as a full array of surgical and diagnostic services, 24 hour nursing care, physician on call, lab, radiology, and physical therapy just to name a few. Our facilities are inspected and follow all state and federal regulations governing hospitals just as every other Kansas hospital would do.

So why is licensure such a pressing matter? Is it access? Our hospitals take all types of patients. Collectively 59% of our patients are covered by Medicare, Medicaid or Worker's Compensation. We all have charity policies and treat the uninsured. The reason our industry

has been singled out is due to purely anti-competitive behaviors by hospitals that would like to legislate rather than compete.

The federal government has looked at the specialty hospital industry extensively since 2002. CMS, HHS, and congress itself have not passed any changes in the definition of our facilities. I would like to share some brief findings of the governments studies, starting with the General Accounting Office report in Oct of 2003 in which it was found:

GAO Report to Congress on Specialty Hospitals, Oct 2003.

- GAO found Surgical Hospitals have a payor mix very similar to General Hospitals
- The GAO study found the average investment was less than 2% and that 73% of the physicians working in a specialty hospital did not have an equity interest in the facility.
- Overall 63% of specialty hospitals had emergency departments.
- The Acuity of procedures is slightly lower than Surgical Hospitals, but not by a large level

In July 2004 a Report by the Federal Trade Commission and the Department of Justice, held 27 days of joint hearings, Feb thru Oct 2003. The hearing gathered testimony of over 250 panelists, and the testimony transcripts are over 6000 pages. The findings were a comparison of what challenges healthcare faces, and what role competition plays in it. At that point they said that 14% of domestic product, or 1.6 trillion dollars are spent on healthcare services in the US. The report examined whether market pressures might be able to bring down the price of healthcare. It was stated that consolidation of hospitals created a market power, thus allowing hospitals to increase their pricing. As hospitals continue to consolidate they have the ability to influence payors by not allowing new entries into the market and also demanding higher prices. The study found that the entries of specialty hospitals, ASC's and other free standing entities, for one, not only improved the market place by pushing the established hospitals to perform more economically and efficiently, but also diluted the market enough that pricing pressures could be effective. The study recommended to get rid of Certificate of Need laws as they felt they were bureaucratic and ineffective, and that consumer preference should dictate the market. They also believed that consumers should become a bigger part of the healthcare decision-making process and should be able to comparison shop among the services available to them.

Medicare Payment Advisory Committee (MedPac) Report March 2005. MedPAC was commissioned to study specialty hospitals under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Five of our member hospitals participated in the study. The primary finding of the study was that the Medicare payment system did not accurately reflect the cost of care. Other findings were;

- The financial impact on community hospitals, in markets with physician owned specialty hospitals, showed that community hospitals were not damaged by the specialty hospital in the market.
- There were some differences in the DRG payments across the board.
- They found the cost was about the same, their recommendations were to improve payment accuracy of inpatient prospective payments, to allow the secretary to address DRG rates, to implement a case mix measure for outlier policies, and to grant the authority to start gain sharing.
- Recent data collected by HHS, MedPAC, and the Government Accountability Office (GAO) demonstrates that little has changed since 2005, when it was found that specialty hospitals posed no negative impact on their neighboring community hospitals.

In Testimony by the Director of Health and Human Services, Dr McClellan, May 2005, before the House Committee on Energy and Commerce. The CMS report found some notable results. For example, it was found that specialty hospitals provide high patient satisfaction, high quality of care, greater predictability in scheduling and services, and significant tax contribution to the community. However, the study did also point out imperfections in current Medicare payment systems.

Dr. McClellan did not recommend that the moratorium be extended. There did not appear to be a referral pattern issue in the 11 hospitals studied. Quality and patient satisfaction was very high. Uncompensated care and benefit levels in addition to real estate and property tax, a portion of sales tax and plus the income tax paid by owners, far exceeded the community benefits of the not-for-profit facilities. His recommendations were to reform hospital inpatient services through the DRG, refine and capture the severity of illness, look at the weight of the DRG system and make sure that the DRG system is a better system.

The specialty hospital model is used throughout the United States. One example is Baylor Health Care of Texas.

- 101 year old faith-based not for profit institution
- 25 joint ventures with Physicians
- 2 heart and 3 surgical hospitals
- Baylor's Heart and Vascular Hospital is the highest rated heart program in the US on the CMS website.
- Since aligning with physicians, Baylor has seen $12 million in cost savings in the first year. Staff turn over at this facility is less than 11%, the rest of the system exceeds 20%.
- Safest in the system, lower liability than the other general hospitals and no medical liability claims in the past three years.

Internationally:
The national health system in England is currently developing 2 surgical hospitals as well as several Ambulatory Surgical Centers in order to better service their citizens.

I would urge this policy group to look at the high satisfaction rates, low infection rates and preferable working environment for physicians and nurses when studying the hospital licensure issue. It would be a shame if the citizens of Kansas lost their opportunity to experience some of the best medical care available because others do not wish to compete. Any term used to describe the Specialty Hospital that does not include the word "Hospital" is a disservice to the great men and women that provide medical care at our hospitals. I have enclosed a fact sheet with my testimony that illustrates how these cutting edge facilities perform compared to the national average and how we as hospitals deliver what we promise to patients, staff, physicians and our communities. As I stated in the beginning, I or any member of our association, will be glad to assist you in any information you might need.

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